FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **Massachusetts**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): **MassHealth**

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
_____ Separate Child Health Program Only
X Combination of the above

Reporting Period: ***Federal Fiscal Year 2003*** *Note: Federal Fiscal Year 2002 starts 10/1/02 and ends 9/30/03.*

Contact Person/Title: **Stephanie Anthony, Director of Federal & National Policy Management**

Address: **600 Washington St. Boston, MA 02111**

Phone: **(617)210-5435** Fax: **(617)210-5697**

Email: **santhony@nt.dma.state.ma.us**

Submission Date: **December 31, 2003**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						From	0	% of FPL conception to birth	225	% of FPL
	From	185	% of FPL for **infants**	200	% of FPL	From	n/a	% of FPL for **infants**	n/a	% of FPL
	From	133	% of FPL for children ages **1 through 5**	150	% of FPL	From	150	% of FPL for 1 **through 18**	200	% of FPL
	From	114	% of FPL for children ages **6 through 17 (DOB>9/30/ 83)**	150	% of FPL					
	From	0	% of FPL for children age **18**	150	% of FPL					

Is presumptive eligibility provided for children?		No		No
	X	Yes, for whom and how long? For children with self-declared income≤ 150% FPL for 60 days	X	Yes, for whom and how long? For children with self–declared family income>150% but≤200% FPL for 60 days

Is retroactive eligibility available?		No		No
	X	Yes, for whom and how long? All children, coverage begins 10 days prior to application	X	Yes, for whom and how long? All children, coverage begins 10 days prior to application

Does your State Plan contain authority to implement a waiting list?	Not applicable	X	No
			Yes

Does your program have a mail-in application?		No		No
	X	Yes	X	Yes

Can an applicant apply for your program over phone?		No		No
	X	Yes	X	Yes

Does your program have an application on your website that can be printed, completed and mailed in?		No		No
	X	Yes	**X**	Yes

Can an applicant apply for your program on-line?	**X**	*No	**X**	*No
	Yes – please check all that apply		Yes – please check all that apply	
		Signature page must be printed and mailed in		Signature page must be printed and mailed in
		Family documentation must be mailed (i.e., income documentation)		Family documentation must be mailed (i.e., income documentation)
		Electronic signature is required		Electronic signature is required
				No Signature is required
		*An eMBR (electronic application) is currently being piloted but is not yet available to all applicants.		*An eMBR (electronic application) is currently being piloted but is not yet available to all applicants.

Does your program require a face-to-face interview during initial application	**X**	No	**X**	No
		Yes		Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	X	No	X	No
		Yes Note: this option requires an 1115 waiver Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6		Yes Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6
	specify number of months		specify number of months	

Does your program provides period of continuous coverage <u>regardless of income changes?</u>	**X**	No	X	No
		Yes		Yes
	specify number of months		specify number of months	
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	However, certain children may receive an additional 12 months of coverage, after an increase in income from earnings, under TMA.			

Does your program	**X**	No		No

require premiums or an enrollment fee?		Yes	X	Yes
	Enrollment fee amount		Enrollment fee amount	N/A
	Premium amount		Premium amount	$12 per child
	Yearly cap		Yearly cap	N/A
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below	
			$12 per child per month up to $36 per month	

Does your program impose co-payments or coinsurance?	**X**	No	**X**	No
		Yes		Yes

Does your program require an assets test?	**X**	No	X	No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	

Is a preprinted renewal form sent prior to eligibility expiring?		No X	X	No
	Yes, we send out form to family with their information precompleted and		Yes, we send out form to family with their information precompleted and	
		we send out form to family with their information pre-completed and ask for confirmation		we send out form to family with their information pre-completed and ask for confirmation ask for confirmation
		we send out form but do not require a response unless income or other circumstances have changed		we send out form but do not require a response unless income or other circumstances have changed

2. Are the income disregards the same for your Medicaid and SCHIP Programs? **N/A** ☐ Yes ☐ No

3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs? ☒ Yes ☐ No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

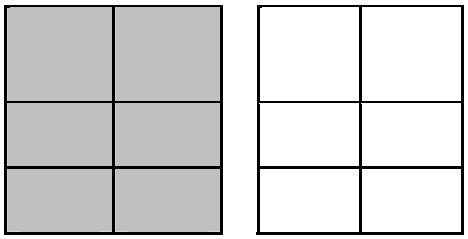
	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)		X		X
b) Application		X		X
c) Benefit structure		X		X
d) Cost sharing structure	X		X	
e) Cost sharing collection process				
f) Crowd out policies		X		X
g) Delivery system		X		X
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)		X		X
i) Eligibility levels / target population		X		X
j) Eligibility redetermination process		X		X
k) Enrollment process for health plan selection		X		X
l) Family coverage		X		X
m) Outreach (e.g., decrease funds, target outreach)		X		X
n) Premium assistance	X		X	
o) Prenatal Eligibility expansion	X		X	
p) Waiver populations (funded under title XXI)		X		X
Parents		X		X
Pregnant women		X		X
Childless adults		X		X

q) Other – please specify **N/A**

a. _____

b. _____

c. _____



5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing structure or e) Cost Sharing collection process (separate?)	The cost of the premium increased from $10 per child per month with a $30 maximum, to $12 per child per month with a $36 maximum. The collection process remains the same.
f) Crowd out policies	
g) Delivery system	
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
i) Eligibility levels / target population	
j) Eligibility redetermination process	
k) Enrollment process for health plan selection	
l) Family coverage	
m) Outreach	
n) Premium assistance	The cost of the premium increased to $12 per child per month to a maximum of $36 per month. This increase, in effect, reduces the amount of premium assistance to the member by $2 per child.

o) Prenatal Eligibility Expansion	In November of 2002 eligibility was extended to the conception to birth category for 0% to 225% FPL. However, as of July 1, 2003, a state plan amendment was submitted reducing the FPL to 200%, that amendment has yet to be approved.

p) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	

q) Other – please specify	
a.	
b.	
c.	

SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program and if the strategic objective listed is new/revised or continuing.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Please include the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives related to Reducing the Number of Uninsured Children		
New/revised _____ Continuing __X___ Expand access to health coverage for low-income children in the Commonwealth.	Reduce the number of uninsured children in the Commonwealth.	Data Sources: Division of Health Care Finance and Policy (DHCFP) Survey on Health Insurance Status and Current Population Survey (CPS) Methodology: Decrease the ratio of uninsured children to insured children from 2:3 to 1:9. Progress summary: DHCFP estimated the ratio at 1:30 in their 2002 (most recent) survey of Health Insurance Status. The CPS March 2003 Supplement estimates the ratio at 1:15. Both estimates indicate that Massachusetts is currently exceeding the state objective.
Objectives Related to SCHIP Enrollment		
New/revised _____ Continuing ___X__ Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low-income children	Implement MassHealth Family Assistance in state fiscal year 1998.	Data Sources: Premium Assistance Summary by Plan Enrollment Snapshot Report Methodology: Measure 1: Comparison of children enrolled in Family Assistance Premium Assistance (FA/PA) with those enrolled in Family Assistance Direct Coverage (FA/DC). Measure 2: Comparison of those in FA/PA who came in insured with those who came in uninsured. Measure 3: Comparison of those in FA/PA who came in uninsured with access to Employer Sponsored Insurance (ESI) and met Title XXI requirements with those who came in uninsured with access to ESI and met 1115 waiver requirements. Numerator: Measure 1: Children in FA/PA as of September 30, 2003 =**4,702** Measure 2: Children in FA/PA who came in uninsured as of September 30, 2003= **2,292** Measure 3: Children in FA/PA who came in uninsured and met Title XXI requirements as of September 30, 2003= **1,831** Denominator: Measure 1: Children in FA/DC as of September 30, 2003= **20,272** Measure 2: Children in FA/PA who came in insured as of September 30, 2003=**2,410** Measure 3: Children in FA/PA who came in uninsured and met 1115 waiver requirements as of September 30, 2003=**403**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Progress Summary: Measure 1: **4,702** children are in FA/PA as of September 30th. An additional **20,272** are in FA/DC. Approximately 19% of children in Family Assistance are in PA. Measure 2: **2,292** children in FA/PA came in uninsured. **2,410** of children in FA/PA came in insured. Approximately 49% of children came in uninsured. Measure 3: **1,831** children met Title XXI requirements for access to ESI. **403** children met the 1115 waiver requirement for access to ESI. Approximately 39% of the children enrolled in FA/PA were enrolled through the Title XXI requirement.
Objectives Related to Increasing Medicaid Enrollment		
New/revised _____ Continuing _____ Improve the efficiency of the eligibility determination process.	Performance Goal A: Develop a streamlined eligibility process by eliminating certain verifications. Performance Goal B: Develop a fully automated eligibility determination process.	Data Sources: Methodology: Progress summary: Goals met prior to FFY03.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
New/revised _____ Continuing _____ N/A		Data Sources: Methodology: Progress summary:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
New/revised _____ Continuing __X___ Improve the health status and well being of children enrolled in MassHealth direct coverage programs, which includes the Primary Care Clinician (PCC) and Manage Care Organization (MCO) Plans	Performance Goal A: Improve the delivery of well child care by measuring the number of well child visits and implementing improvement activities as appropriate. Performance Goal B: Improve the immunization rates by measuring the rate of immunization administration and implement improvement activities as appropriate.	Data Sources: HEDIS, Summary Analysis of Clinical Indicators, Primary Care Clinician (PCC) Plan Profile Reports, CMS 416 Report, DPH MIP, Clinical Topic Review. Methodology: Performance Goal A: 1) The PCC Profile Report provided PCC-specific data on the rate at which children enrolled with the PCC receive well-child care. The PCC Reminder Report continued to list children who are overdue for visits. MassHealth also: 2) continued to use the Recommendations for Pediatric Preventive Care, adopted by the Massachusetts Health Quality Partners, as its standard for well-child care; 3) continued to produce a set of materials to support providers around well child care including "Help Your Child Grow Up Healthy," (in multiple languages to remind members about the well child care visit schedule and the importance of immunization), Choosing a Doctor or Nurse for Your Child, Growth Chart, and Reminder Cards; 4) continued work on the MassHealth Adolescent Anticipatory Guidance Public Awareness Campaign (MAAGPAC) an effort to increase adolescent annual well childcare visit rates, enlisted a vendor to engage teens, parents and providers in message development for the project; 5) produced an article for inclusion in the member newsletter to highlight the importance of well childcare; 6) led a workgroup composed of representatives of the PCC Plan and the MCO's, this group works collaboratively on improvement activities; 7) coordinated with other state agencies and advocacy

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		groups such as the Childhood Lead Poisoning Prevention Program, WIC, First Steps, First Link, Healthy Families and the Consortium for Children with Special Health Care Needs to promote access for MassHealth eligible children; and 8) analyzed data for children in the care and custody of DSS to identify areas of improvement in access to care. Numerator: Number of MassHealth enrolled children who had a well child visit in accordance with the EPSDT Medical Protocol and Periodicity Schedule. Denominator: Number of MassHealth enrolled children. Progress Summary: Performance Goal A: FFY02 CMS 416 EPSDT Report Participation Ratio of 66% (participation ratio compares the number of children and adolescents who were due to receive a visit within the reporting period with the number who actually received a visit) Methodology: Performance Goal B: 1) Participation in the CMS/CDC Government Performance Results Act (GPRA) Immunization Initiative to improve immunization rates for 2 year olds, a PCC Plan representative attended and presented at the 2003 annual GPRA conference to share information and learn from other states on best practices around increasing immunization rates. 2) The Division continued to work closely with the DPH Massachusetts Immunization Program (MIP) on efforts to improve the rate at which MassHealth enrolled children are immunized. 3) The Division continues to produce and distribute a booklet jointly prepared by the Division, its contracted MCO's, the MIP and UMass Center for Health Policy and Research and titled "Best Practices to Prevent Missed Opportunities in Childhood Immunization." 4) The Division participated in the MHQP endorsement of the DPH childhood Immunization Guidelines. MHQP distributed the immunization guidelines and recommended childhood schedule along with the "Missed Opportunities" publication. Numerator: # of children received 4DTP/DtaP, 3 Polio (IPV/OPV) 1 MMR, 3 HepB, 1Hib. Denominator: # of children who turn 2 in 2001, continuously enrolled in MCO or PCC Plan for 12 months preceding 2nd birthday, with no more than one gap in enrollment up to 45 days. Progress Summary: From the MassHealth Managed Care HEDIS 2002 Report, the MassHealth mean for the combination of vaccines 4 DTP/DtaP, 3 Polio, 1MMR, 1Hib, and 3 Hep B was 75.1% up from 69.1% from HEDIS 2000.

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?

As MassHealth members, SCHIP eligible children are included in various MassHealth quality activities. In 2002, the Division conducted Clinical Topic Reviews in the area of child immunization, adolescent immunization, and asthma in children. In 2003 the Division conducted a Clinical Topic Review in the area of perinatal care. Data has been collected and analysis is underway. Final reports are due in FFY04. Copies of the Clinical Topic Review reports are available upon request.

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?

The Division plans to continue monitoring access and quality through its member survey and Clinical Topic Reviews.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

Please see response to question 2 above.

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

The Division conducts member satisfaction surveys biannually. There was no survey this year; it will be conducted in FY04. A copy of the 2002 report is available upon request.

REPORTING OF NATIONAL PERFORMANCE MEASURES

The Centers for Medicare & Medicaid Services (CMS) convened the Performance Measurement Partnership Project (PMPP) as a collaborative effort between Federal and state officials to develop a national set of performance measures for Medicaid and the State Children's Health Insurance Programs (SCHIP). CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001 and the Medicaid Final Rules of June 14, 2002 on managed care.

The PMPP's stated goal is to create a short list of performance measures relevant to those enrolled in Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of some 19 measures, the PMPP group trimmed the list to the following seven core measures (SCHIP states should report on all applicable measures for covered populations to the extent that data is available):

- Well child visits for children in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Comprehensive diabetes care (hemoglobin A1c tests)
- Children's access to primary care services
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

Work remains to resolve technical issues related to implementing the collection, analysis, and reporting of the measures. ***If your State currently has data on any of these measures***, please report them using the format below. Indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

The Division is currently not participating in the PMPP. However some of these measures are collected under HEDIS. The 2002 and 2003 HEDIS reports are available upon request.

Measure	**Describe how it is measured**	
Well child visits for children in the first 15 months of life	HEDIS 2002	Data Sources: HEDIS Methodology: Progress Summary: MassHealth Weighted Mean: 61.9% of MassHealth managed care members had 6 or more well-child visits in their first 15 months of life.
Well child visits in the 3rd, 4th, 5th, and 6th years of life	HEDIS 2002	Data Sources: HEDIS Methodology: Progress Summary: MassHealth Weighted Mean: 75.3% had a well child visit.
Use of appropriate medications for children with asthma	Will be collected for HEDIS in 2004	Data Sources: Methodology: Progress Summary:
Comprehensive diabetes care (hemoglobin A1c tests)	HEDIS 2002: Collected only for adults age 18-64	Data Sources: Methodology: Progress Summary:
Children's access to primary care services	HEDIS 2002	Data Sources: HEDIS Methodology: Progress Summary:

		Age 12-24 months: MassHealth Weighted Mean: 92.9% had at least one visit. Age 25 months to 6 yrs: MassHealth Weighted Mean: 89.2% had at least one visit. Age 7-11 yrs: MassHealth Weighted Mean: 94.9% had at least one visit.
Adult access to preventive/ambulatory health services	Not Collected	Data Sources: Methodology: Progress Summary:
Prenatal and postpartum care (prenatal visits)	HEDIS 2003	Data Sources: HEDIS Methodology: Progress Summary: Timeliness of Prenatal Care: MassHealth Mean: 83% of women received timely prenatal care Frequency of Ongoing Prenatal Care: Overall 65% of pregnant MassHealth Women received 81% of their expected prenatal visits. Postpartum Care: MassHealth Mean: 53% had a post partum visit 21-56 days after delivery.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

ENROLLMENT

1. Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).

82,209	SCHIP Medicaid Expansion Program (SEDS form 64.21E)	42,968*	Separate Child Health Program (SEDS form 21E)

* The number reported last year under the Separate Child Health Program was incorrect. The number of children ever enrolled from the 4th quarter report of FY02 should have been stated as 39,453, not the 22,613 included in last year's annual report.

2. Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.

The Massachusetts Survey of Health Insurance Status 2002 (the most current survey) conducted by the state Division of Health Care Finance and Policy (DHCFP) reported the uninsurance rate for children (0-18) was 3.2% in 2002. This compares to 3.0% in 2000 and 6.3% in 1998 for the same survey. While this survey shows a slight increase in uninsured children this increase is not statistically significant. There has been a significant increase in uninsured adults for the same period in Massachusetts.

The Current Population Survey (CPS) March supplement reported an uninsurance rate for children (age 0-18) as follows: March 2000: 9.1%; March 2001: 8.4%; March 2002: 5.5%; and March 2003: 6.1%.

3. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program, please skip to #4)***

The Division's outreach activities do not specifically target the SCHIP population, but all children eligible for MassHealth; therefore, the Division cannot estimate the number of children enrolled in Medicaid through these activities.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?

   Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

   X No, skip to the Outreach subsection, below

   _____ Yes, please provide your new baseline _____ And continue on to question 5

5. On which source does your State currently base its baseline estimate of uninsured children?

   _____ The March supplement to the Current Population Survey (CPS)

   _____ A State-specific survey

   _____ A statistically adjusted CPS

_____ Another appropriate source

A. What was the justification for adopting a different methodology?

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

No

2. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The Division has ongoing school outreach activities which include: encouraging Massachusetts schools to actively review a child's health insurance status at appropriate opportunities within the school year; maintaining efforts to promote the inclusion of a question about the child's health insurance coverage on the student emergency card maintained by the school; and continuing support of collaboration with the local health care access project grantees to provide information and assist families with health insurance enrollment.

Massachusetts continues as a Robert Wood Johnson Foundation Covering Kids' site, collaborating with Health Care for All. The Division also continues to work with the medical community including the Massachusetts Hospital Association, the Massachusetts Medical Society and the American Academy of Pediatrics to promote the MassHealth program. Providers are encouraged to participate in training sessions on MassHealth and are supplied with enrollment kits titled "What to do when an Uninsured Child Shows up at your Door."

3. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Outreach activities include print, TV, and radio advertisements to the Latino, Portuguese, Cambodian, Russian, and Chinese communities. The Division also continues to sponsor a program on the local Spanish speaking television network. The Division continues to translate materials into Spanish, Portuguese, Chinese, Vietnamese, Haitian Creole, Russian, Cambodian, Laotian, French, and Arabic.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

All States must complete the following 3 questions

1. Describe how substitution of coverage is monitored and measured.

If a child with family income between 150% and 200% of FPL appears to have access to health insurance through an employer, the Division conducts a health insurance investigation to determine if the insurance meets Division standards and is cost effective. If there is access to qualified health insurance coverage, the children will be eligible for premium assistance toward the cost of their employer-sponsored insurance.

2. Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?

Because the Division requires that those with employer sponsored insurance that is cost effective and meets the basic benefit level to purchase that insurance, there is no substitution.

3. At the time of application, what percent of applicants are found to have insurance?

For those members whose income is between 150-200% of FPL, approximately 42% of applicants had insurance at the time of application.

States with separate child health programs over 200% of FPL must complete question 4

4. Identify your substitution prevention provisions (waiting periods, etc.).

States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.

5. Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

States with waiting period requirements must complete question 6. (This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)

6. Identify any exceptions to your waiting period requirement.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

The Division does not differentiate between children enrolling in MassHealth and children enrolling in MassHealth due to SCHIP eligibility. The redetermination procedures are the same for all children.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.

The Division does not differentiate between children enrolling in MassHealth and children enrolling in MassHealth due to SCHIP eligibility. As long as the child remains eligible for MassHealth, movement among categories of assistance are seamless to the member.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain

The Division does not differentiate between children enrolling in MassHealth and children enrolling in MassHealth due to SCHIP eligibility. All children enrolled in MassHealth have access to the same delivery systems.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? *Check all that apply*.

____ Follow-up by caseworkers/outreach workers

__x__ Renewal reminder notices to all families, *specify how many notices and when notified*
Initial notice with 30 days to respond.

____ Targeted mailing to selected populations, *specify population* _____

____ Information campaigns

____ Simplification of re-enrollment process, *please describe* _____

____ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please describe* _____

____ Other, *please explain* _____

2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

Renewal reminder notices have been effective, however, due to budgetary constraints; additional reminder notices have been discontinued.

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or move?) If so, describe the data source and method used to derive this information.

No, due to the nature and complexity of the administrative data, this type of analysis has not been undertaken.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Due to the complexity of the data, it is difficult to accurately measure the effect of premiums on the MassHealth population. It is estimated that approximately one quarter of those paying premiums in the Family Assistance Direct Coverage program close out of MassHealth for non-payment of premium. However, we know that in some cases where it appears families closed for non-payment, they did in fact close for other reasons. It is problematic to determine the exact reasons for closure and/or non-payment of the premium from administrative data.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

No

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program using title XXI funds under any of the following authorities?

____ No, skip to Section IV.

__X__ Yes, Check all that apply and complete each question for each authority.
__X__ State plan
____ Family Coverage
____ Section 1115 Demonstration
____ Health Insurance Accountability &Flexibility Demonstration
____ HIPP

2. Briefly describe your program (including current status, progress, difficulties, etc.)

The MassHealth Family Assistance Premium Assistance program is designed to make employer sponsored insurance (ESI) affordable to low-income workers. Premium Assistance offers subsidies, on behalf of eligible MassHealth members to help low-wage workers pay their share of ESI for child(ren).

The Division requires that the ESI meet the following minimum requirements: the employers must contribute at least 50% to the cost of the health insurance premium, the offered plan must meet the basic benefit level, and providing premium assistance must be cost effective for the Commonwealth. In order to meet the cost sharing requirements, out of pocket expenses to the member cannot exceed 5% of the family's income.

2. What benefit package does the program use?

Secretary approved per the state plan amendment approved in March 2002.

3. Does the program provide wrap-around coverage for benefits or cost sharing?

No

4. Identify the total number of children and adults enrolled in the premium assistance program for whom title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

* Number of adults ever enrolled during the reporting period

* Number of children ever enrolled during the reporting period

*The Division does not maintain the data in the format requested above. However, as of September 30, 2003, 1,831 children were enrolled in FA/PA. The Division continues to estimate that an additional 1.5 adults per child are covered by default.

5. Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program. How was this measured?

See Substitution of Coverage Section, Question 2.

6. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

While children are the primary beneficiaries of the program, adults also benefit by obtaining access to health insurance by default. The Division purchases the family plan from the employer to cover the children and parents are then covered as well.

7.What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

The Division has not estimated the impact of premium assistance on enrollment and retention of children.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. (*Note: This reporting period = Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Insurance payments	**$1,530,000***	**$1,759,500**	**$2,023,425**
Managed Care	**$34,045,558**	$39,152,392	$45,025,251
Per member/Per month rate @ # of eligibles			
Fee for Service	**$73,034,592****	$83,989,781	$96,588,248
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	**$108,610,151**	**$124,901,673**	**$143,636,924**

Administration Costs			
Personnel			
General Administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other			
Total Administration Costs	**$1,597,611**	**$1,837,252**	**$2,112,840**
10% Administrative Cap (net benefit costs ÷ 9)	**$12,067,795**	**$13,877,964**	**$15,959,658**

Federal Title XXI Share	**71,635,045**	**82,380,302**	**94,737,347**
State Share	**38,572,717**	**44,358,624**	**51,012,418**

TOTAL COSTS OF APPROVED SCHIP PLAN	**110,207,762**	**126,738,926**	**145,749,765**

*Expenditures for premium assistance payments for FFY03 are estimated
**Fee for service includes spending on the PCC Plan

2. What were the sources of non-Federal funding used for State match during the reporting period?

- **X** State appropriations
- _____ County/local funds
- _____ Employer contributions
- _____ Foundation grants
- _____ Private donations (such as United Way, sponsorship)
- _____ Other (specify)

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

N/A to Massachusetts

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration on enrollment, retention, and access to care of children?

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. *Note: This reporting period (Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	Reporting Period	Next Fiscal Year	Following Fiscal Year
Benefit Costs for Demonstration Population #1 (e.g., children)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #1			
Benefit Costs for Demonstration Population #2 (e.g., parents)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #2			
Benefit Costs for Demonstration Population #3 (e.g., pregnant women)			

Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #3			

Total Benefit Costs			
(Offsetting Beneficiary Cost Sharing Payments)			
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)			

Administration Costs

Personnel			
General Administration			
Contractors/Brokers *(e.g., enrollment contractors)*			
Claims Processing			
Outreach/Marketing costs			
Other *(specify)*			
Total Administration Costs			
10% Administrative Cap (net benefit costs ÷ 9)			

Federal Title XXI Share			
State Share			

TOTAL COSTS OF DEMONSTRATION			

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

During the reporting period, the Commonwealth continued to face a significant budget crisis. Despite this, the MassHealth program remained largely intact. Although some cost cutting measures were necessary, they were made while placing a priority on preserving eligibility to the extent possible. Most of the changes were directed at adult populations; however, the change most likely to affect children is the increase in premiums of MassHealth members in Family Assistance, implemented in March 2003. Premiums were increased from $10 per child per month, maximum $30 per month, to $12 per child per month, maximum of $36 per month.

Despite this, the rate of uninsurance in Massachusetts, while increasing slightly, remains low. According to the CPS's March 2003 Supplement, the rate of uninsured children age 0-18 is 6.1%. MassHealth has been widely recognized as an important factor in the state's ability to keep uninsurance rates in check during the economic downturn of the last two years.

Also, during the reporting period, the Commonwealth began a multi-year process to reorganize state government. Under this new plan, the Executive Office of Health and Human Services (EOHHS) will become the single state agency responsible for the Medicaid program.

2. During the reporting period, what has been the greatest challenge your program has experienced?

Maintaining the program given the budget issues has been the greatest challenge during the reporting period.

3. During the reporting period, what accomplishments have been achieved in your program?

MassHealth has been successful in continuing to maintain children's enrollment in the program, and there has been no indication of any significant increase in the rate of uninsurance in children.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

The budget crisis is expected to continue into the next year and the Division will take steps to slow the growth of the MassHealth program's costs. However, the Division does not anticipate any significant changes to our SCHIP program in FFY04.